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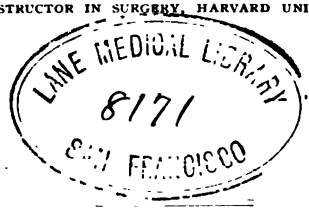

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1904

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PREFACE.

The following histories of cases have been collected and printed to facilitate the case method of teaching in surgery at the Harvard Medical School. Dr. Blake has for three years found that in the latter part of the last year in the course in surgical instruction this method of teaching has served to assemble the more or less disjointed knowledge that the students have acquired in the various fundamental and applied courses.

The writers believe that the case method needs wider recognition in the art of teaching surgery. There are many and varied advantages in the method. It gives the instructor a boundless amount of material; he may utilize all his histories in private and hospital practice; he may use the histories of cases that have been under the care of other surgeons; he may present cases that illustrate the variations in the common forms of disease; he may collect rare and unique examples of disease; he may present histories that are complete or incomplete; and he may, if he chooses, omit important details from the history of a case.

The most important advantage that the method presents is its adaptability and elasticity to the needs of the instructor. No one can make a success of this method unless he adopts his own individual way of conducting the exercises. The instructor should guide and suggest, but the student should talk and discuss the case. In other words, the student should be active and productive, rather than passive and receptive. Each instructor, after trying the method will adopt a plan of his own and, after all, this is the fundamental principle of good teaching. A very definite advantage is that the instructor may develop the instruction along whatever lines he may elect; for example, the discussion of a case may bear upon etiology, symptomatology, diagnosis, differential diagnosis, prognosis, or treatment. A very definite advantage to the instructor is that, if the students are allowed to do the questioning, they will quickly demonstrate their need of instruction, whether it be in diagnosis, prognosis, or treatment.

In the explanatory note Dr. Blake describes his personal method of using case teaching in surgery. It is hoped to make the cases

more interesting by withholding the diagnosis. The key will be mailed to instructors who wish it.

It is necessary to emphasize the fact that the case method is not intended as a substitute for the accepted methods of surgical teaching. These are the lecture, the clinic, the quiz, and the small bedside section. To them, however, the case method may be made to act as a supplement, filling gaps which may exist between them, and developing needs of students which would otherwise have escaped observation.

We desire to acknowledge the valuable assistance of Dr. W. C. Peters, who has with much care selected a number of the following cases.

EXPLANATORY NOTE.

A method of conducting the case teaching exercises which has proved satisfactory, is as follows:

The instructor reads the selected case to the assembled class; legitimate questions concerning the text are answered, and missing information that may properly be supplied is given, if requested by the students. Five to ten minutes are allowed for silent consideration of the case, and the discussion is then commenced. One of the class is asked to summarize the case; for example: "This is an acute abdominal attack in an old man," "a chronic gastric condition with an exacerbation, in a middle-aged woman," etc. This is, of course, merely pointing the direction in which the diagnosis lies; yet it serves as a point of departure. Possibilities are considered and ruled out as rapidly as may be, the instructor taking care that the student does the talking, makes the suggestions, and raises the objections. When a positive diagnosis is reached, or if individuals differ in diagnoses, the instructor may proceed to treatment, which should be discussed in its widest aspect and its minutest details. It is well to ask the students to consider the case as if it were not in a hospital, but in circumstances where the doctor must give accurate directions and personal supervision to every detail of treatment. If an operation is indicated, the time, the preparation, the anesthetic, the stimulation, the immediate after-treatment, as well as each step of the operation itself, must be most thoroughly covered.

The prognosis is to be approached from the practical standpoint of the man who wants to know when he may return to work. The possibility of late sequelæ, of recurrent attacks, of contagion, etc., are also to be viewed from the essentially practical point of view.

Last of all, the correct diagnosis and a narrative of operation, results, convalescence, or the full detail of the autopsy in fatal cases is announced by the instructor. In the light of the diagnosis, the case may then be advantageously and briefly reviewed,—important points emphasized, symptoms which were puzzling or apparently unimportant interpreted, and the case summarized again in the manner best fitted to impress its salient points upon the students' attention.

If the exercise is of two hours' duration, it is sometimes well worth while to follow the first by a second case illustrating another type or example of the same disease. This is particularly to be desired when the cases of the same disease differ essentially in treatment and prognosis. The writers believe these cases should not be used to simply establish a diagnosis. For purposes of instruction, the diagnosis is the least valuable factor. The points of interest in these cases should be used as pegs upon which to hang useful information.

LIST OF ABBREVIATIONS.

For the sake of brevity, the following abbreviations are frequently used:

Gen.,.....General.
Abd.,.....Abdomen.
Ant., ...Anterior.
Post.,.....Posterior.
Fam. Hist., ..Family History.
Prev. Hist., ..Previous History.
Pres. Ill., ...Present Illness.
Phys. Exam., .Physical Examination.
H. & L.,.....Heart and Lungs.
W. D. & N., .Well developed and nourished.
T., ...Temperature.
Nor., ...Normal.
P., ...Pulse.
Sl.,.....Slight.
Lt., ...Left.
Rt.,.....Right.
Neg., ...Negative.
Ur., ...Urine.
Resp., ...Respiration.
M., ...Male.
F., ...Female.
Mod., ...Moderate.
Exam., ...Examination.
Tend.,.....Tenderness.
Mos.,.....Months.
Yrs., ...Years.

Figures immediately following the patient's name indicate his age.

CASE 1.

Male; 47; married; carpenter.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—While at work this afternoon a piece of timber flew from a circular saw and struck patient in abdomen. Felt faint and vomited, but soon felt better, walked around and was taken home in a carriage. Pain and nausea returned. Was given morphia by physician and sent to hospital four hours after accident.

Phys. Exam.—Well developed and nourished. Temperature, 101°; pulse 100, strong. Looks sick; drowsy, but easily aroused. Abdominal wall very rigid, but not distended. Slightly pale. General abdominal tenderness, most marked in left iliac fossa, where there is a slight superficial contusion. Dullness over pubes at both sides extending into left iliac region. Four ounces of apparently normal urine drawn by catheter. No leucocytosis. Bowels moved slightly after enema. Nothing abnormal in stool.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 2.

Male; 53; married; engineer.

Transferred from Medical Side.

Fam. Hist.—Father died of alcohol; mother died of milk leg; sister died in child-bed.

Prev. Hist.—Malaria in 1886, rheumatic fever in 1876; frequent rheumatic attacks since, particularly in 1885. No venereal. At times alcohol to excess.

Pres. Ill. (August 5th).—For eight years trouble with heart, dyspnea and precordial pain. Sent to Soldiers' Home for seven months and returned to it twice again. Has worked but little. Some cough, no blood. Headache with vertigo at times. Legs swollen at times for ten years. Micturition, two to five times at night.

Phys. Exam.—*Pupils*, equal and react. Pulse regular, small, poor volume and tension, 110. Temperature, 99.5°. *Heart*, much enlarged to right and left; double murmur at apex; systolic heard also at base. *Lungs*, dullness and diminished resonance, fine and medium moist râles below fifth rib, sides, and back. *Abdomen*, negative. *Urine*, N. 1023, acid; slight trace albumen; some brown granular casts; many hyaline and fine granular casts, some with blood and leucocytes adherent. Slight amount of abnormal blood; many small round cells; some squamous and neck of bladder cells. Was given digitalis and potassium acetate.

August 20th: Vomiting; no other abdominal symptoms. Digitalis stopped.

August 22d: Absence of fremitus and respiration in lower right back; beginning abdominal tenderness and pain, becoming severe. Vomiting.

August 23d: Tympanites with tenderness, retching, and nausea.

August 24th: General moderate distention, with universal spasm; pulse and temperature rising. Attacks of sharp abdominal pain, which disappear and recur. Constipation. No leucocytosis.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 3.

Female; 24; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Patient states that five days ago she stepped on a rusty nail. That evening had chilly sensation and malaise. Distinct chill every evening since. Vomited last night. Foot almost immediately became reddened and tender. Poulticed. Doctor told her last night that her temperature was 106°.

Phys. Exam.—Well developed and nourished; stout. Temperature, 98.4°; pulse 80, good volume and tension. Thorax and abdomen negative, save that edge of spleen and liver can be palpated. Right foot not swollen nor tender, no redness or pain. Small recent scar. No lymphangitis. White count, 12,000.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 4.

Female; 51; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—For more than one year patient has had urinary symptoms; has passed blood at times.

Pres. Ill.—At 4 A.M. yesterday patient was seized with severe abdominal pain, not localized. Vomited greenish fluid several times. Grew worse without remission of symptoms. Had been working and feeling as well as usual up to yesterday. Constipated for past two days.

Phys. Exam.—W. D. & N. Obese. Mentally dull. Patient's history contradictory. Does not look extremely sick. Pupils small and equal, conjunctiva not yellow. Tongue coated. Vomiting. Pulse rapid, poor quality. Heart and lungs not examined. Abdomen considerably distended. Moderate general tenderness. Considerable general spasm. No flatness. No tumor felt. Vaginal examination shows cervix high, just in reach of fingers. Negative except for bloody discharge. No leucocytosis.

High enema, poor result. Several unsuccessful attempts to catheterize made by nurse. House officer found greenish ring around meatus, and with catheter drew a few ounces of dark, bloody, foul-smelling fluid.

Urine dark, 1015. Alk. ¼% alb. Large amount of sediment. Normal blood. Few large round cells and squamous epithelium.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 5.

Male; 30; married; stableman.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Friend states that four days ago patient fell from bicycle, injuring head. Wounds dressed by physician. Patient normal until 2 A.M. to-day, when sudden delirium, requiring restraint, developed.

Phys. Exam.—Unconscious. Pupils equal and react. Divergent strabismus; right eye most affected. Pulse 60, good volume, high tension; temperature, 99°. Respiration, Cheyne-Stokes. Whole right face moves less than left. Responds to supra-orbital pressure by irregular movements. Heart, lungs, and abdomen negative. Urine normal. Right arm moves less than left. Reflexes present. Babinsky on both sides. Leucocytosis, 11,000. Slight general muscular spasm.

Head.—Oval depression, size of five-cent piece, ¼ inch deep, in median line, upper occipital region. Two recent wounds, one inch above right eyebrow, sutured. No bleeding from ears or nose. Ear drums normal.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 6.

Female; 25; single; waitress.

Fam. Hist.—Negative.

Prev. Hist.—Always well and strong.

Pres. Ill.—Two days ago sudden pain in right hypochondrium, steady, sharp and shooting into right iliac region. Nausea and vomiting. No chills. Pain continued during night; morphia given next day. Yesterday symptoms recurred. This morning, pain localized in right iliac; vomiting incessant, no diarrhea. Came to hospital in ambulance. Leucocytosis, 10,600.

Phys. Exam.—F. D. & N. Heart and lungs negative. Urine negative. Temperature, 100°; pulse, 80. Abdomen somewhat distended, especially below umbilicus, more on left than right. Somewhat rigid. Tense in lower left quadrant. Dullness below umbilicus. A well-marked resistance, but no definite tumor made out in left lower quadrant.

Vaginal Exam.—Cervix short, smooth, normal density; body of uterus not felt. Tenderness to left, and soft smooth mass filling posterior cul-de-sac. No vaginal nor urethral discharge.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 7.

Female; 22; single; factory girl.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—For four months gradual weakness, anorexia, night-sweats, cough, fever, loss of flesh, pain in chest. Three days ago chill, fever, pain in right chest and increasing fullness.

Phys. Exam.—Respiration, 35; pulse, 126; temperature, 102.5°. Pale. Heart and lower abdomen negative. Liver enlarged (?). Entire right chest dull. Respiratory sounds diminished in upper part. Respiration and fremitus absent below.

Pulse and temperature gradually diminished, and a tumor appeared in the right hypochondrium which was tender, dull on percussion and not distinctly fluctuating. Aspiration of chest in right axillary line revealed a serous liquid, slightly hemorrhagic. The area of dullness increased. One week later tapped again; nothing obtained. Leucocytes, 13 800. Hemoglobin, 50%. Slight constipation. Temperature and pulse continue to oscillate moderately. Patient looks very sick.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 8.

Male; 4¼ years.

Fam. Hist.—Negative.

Prev. Hist.—Pneumonia two years ago. Diphtheria one year ago.

Pres. Ill.—Three days ago developed headache and began to vomit. Has vomited all food since. General abdominal pain. Feverish. No chills or convulsions.

Phys. Exam.—Well developed and poorly nourished. General condition very poor. Temperature, 104.8°; pulse, 155. Respiration, 40. Heart negative. Lungs: diminished breathing in right axillary line; some questionable râles at the same place. No dullness. Abdomen tympanitic. General abdominal distention and tenderness. No muscular spasm. Tonsils red and swollen. No patches. Pathology: No Bacillus diphtheriæ found. Urine slightly turbid, 1022; acid slight trace. Amorp. urates in excess. Few fine granular casts.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 9.

Female; 49; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—Two attacks like the present, three and five years ago.

Pres. Ill.—Sixty hours ago, onset in upper abdomen of steadily increasing pain, with acute brief exacerbations. Retching and vomiting during first twenty-four hours, but no blood or intestinal contents in vomitus. Bowels have not moved since pain began. No chills.

Phys. Exam.—Well developed and nourished. Temperature, 99.4°; pulse, 130, poor volume and tension. Perfectly conscious. Left chest negative. Right chest, pleuritic friction rub from fourth rib down, in axillary line; no effusion. *Abdomen* distended. Considerable voluntary and slight involuntary general muscular spasm. Considerable tenderness of upper abdomen, most marked on right. Dull in flanks, elsewhere tympanitic. No tumor felt. Visible peristalsis to right of median line. Exploratory laparotomy considered, but decided against chiefly on account of poor general condition. High enema; poor result.

April 14th: Condition has improved slightly during past ten days. Considerable tenderness in left hypochondrium, where there is now an indefinite, tender, firm mass. Urine, 50 to 60 ounces, turbid, light colored, 1022, alb. slight trace; pus free and in clumps. Bowels moving daily. No vomiting.

April 24th: Chill; for following four days temperature was 100° to 101°; pulse, 120. Urine still contains pus. Tumor unchanged. Leucocytes less than 14,000.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 10.

Male; 23; single; clerk.

Fam. Hist.—Negative, except that mother is "very nervous."

Prev. Hist.—Typhoid eighteen months ago. Lasted four and one-half months; complicated by gonorrhea and an "abscess of testicle" which was incised during typhoid. Is of neurotic temperament and has had a severe nervous shock recently.

Pres. Ill.—Coryza and cough for three days; confined to his room in Boston. Last night his uncle left the room for twenty minutes and returned to find patient semi-conscious and talking incoherently, lying on a lounge where he had left him, with a shotgun by his side.

Phys. Exam.—Well developed and nourished. Slight bronchitis. Heart slightly irregular in rhythm and force. No murmurs; no enlargement. Pulse, 100; temperature, 102°. Pupils equal and react. Eyes slightly bloodshot. Face otherwise normal in appearance. Paresis of left arm and leg. Left thumb flexed across palm, fingers partly flexed. Grip very weak. Left knee-jerk increased, right normal. Absolute anesthesia and analgesia of left hand, diminishing in severity up the arm and in leg. Cannot cross left leg over right. After about one hour begins to answer some questions rationally, but thinks he is at home in the country and was struck on head while hunting. No injury of head found, but soreness in left frontal region. No incontinence, nausea, vomiting, collapse. No signs of violence.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 11.

Female; 26; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Knocked down this morning by a team, twisting right leg. Pain and immediate disability.

Phys. Exam. (January 22d).—Heart and lung negative. Well developed and nourished. Pupils equal and react to light. Marked odor of alcohol on breath. On right leg is a lacerated wound one inch long, three inches above the ankle, through which the broken ends of tibia and fibula protrude. Tibia is comminuted. No other fractures. Urine negative. What is the treatment?

Later Hist. (January 23d and 24th).—Patient comfortable but restless.

January 25th: Slight rise in afternoon temperature.

January 26th: Temperature, 102°; pulse, 110. No apparent cause. Lungs and abdomen negative. Wound healing by first intention.

On following two days no marked change. On January 29th patient slightly delirious. Pulse varies from 100 to 120. Temperature, 100° to 101°. At 10 P.M. patient complained of feeling faint; nurse telephoned for house surgeon. Three minutes later patient became unconscious; face gray, with slight cyanosis of lips and fingers; extremities cold; pulse imperceptible; marked dyspnea and stertorous respiration—30 a minute. No sweating, cardiac action irregular, tumultuous and intermittent; coarse râles throughout right chest; otherwise lungs normal; respiration gradually decreased to 10.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 12.

Male; 38; married; laborer.

Fam. Hist.—Negative.

Prev. Hist.—Pleurisy a year and a half ago. One year ago "abscess" in right side of chest, which burst spontaneously and has discharged ever since.

Pres. Ill.—Three or four months ago began to "run down"; short of breath; considerable cough. Has steadily grown worse. Vomits occasionally. Has lost thirty pounds. Feels feverish in the afternoon.

Phys. Exam.—Well developed and poorly nourished. Temperature, 102.8°; pulse 120, fair volume and tension. Heart slightly enlarged, apex 5th space, left nipple line. No murmurs. Arteries stiff. Tongue has a brown coat. Abdomen negative. General condition poor. Respiration shallow and labored. Urine negative. Lungs: numerous moist râles. Right chest: dullness and diminished respiration below third rib, front, and spine of scapula posteriorly; also diminished voice-sounds and fremitus. Sinus in anterior right axillary line, 5th space, from which thin watery pus slowly escapes. Temperature rapidly fell to normal.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 13.

Male; 59; married; laborer.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Eight days ago severe pain began in left abdomen; felt chilly. Soon after noticed swelling at seat of pain, which gradually and then rapidly increased in size, with marked pain and tenderness. Constipation for one week. Has vomited everything eaten for three days.

Phys. Exam.—Well developed and poorly nourished. Pulse 98, good quality; temperature, 102.8°. Tongue slightly coated. Heart and lung negative. Abdomen on left side, midway between ribs and ilium, large fluctuating tumor dull on percussion, tender, and suggesting fluid under high tension. Seems attached to abdominal wall. Hard to grasp overlying skin between fingers. Examination causes extreme pain. Abdomen otherwise negative. Urine negative. Vaginal examination negative save for torn perineum. Leucocytosis, 22,000.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 14.

Male; 32; married; waiter.

Fam. Hist.—Negative.

Prev. Hist.—Moderate alcohol. Gonorrhea fifteen years ago. Denies syphilis. Ulcer on penis, with suppurating bubo in groin, eight years ago. Six months ago moderate constant pain began in epigastrium and right hypochondrium, which lasted two and a half months. Soon after, marked swelling of right leg below knee without pain or tenderness. This continued two months. No jaundice, no cough. Has lost flesh, but regained it.

Pres. Ill.—Three months ago first noticed that belly was swollen. This swelling has increased and now causes dyspnea. No pain. Slight constipation. Six days ago, abdomen tapped and considerable liquid removed; has continued to escape by drops. Has lost nine pounds in weight. Urine negative.

Phys. Exam.—Well developed and poorly nourished. Temperature, 100.8°; pulse 108, good volume and tension. Heart-sounds weak; no murmur. Lungs negative. Abdomen distended; dullness in flanks, changing with position. Liver felt two fingers below ribs. General abdominal tenderness. No tumor found. Straw-colored transparent fluid] escapes slowly from puncture one inch below umbilicus. Leucocytosis, 11,000. Small varicose veins on both legs. Gets up once at night to pass water. Urine 1015, pale, acid, slightest possible trace albumen.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 15.

Male; 23; single; brass worker.

Fam. Hist.—Negative.

Prev. Hist.—For thirteen years has had in left knee occasional swelling, pain, and tenderness, and inability to completely flex or extend leg. Between attacks, knee apparently normal.

Pres. Ill. (October 15th).—For two weeks a severe attack similar to above. Pain so severe that patient could not sleep or bear weight on foot. Patient well except knee.

Phys. Exam.—Well developed and nourished. Pulse, 80; temperature, 99°. Heart, lung, and abdomen negative. Left knee swollen, tender and slightly reddened; normal dimples obliterated; patella floats; fluctuation in joint; can flex leg to within 5° normal, and almost completely extend it. Considerable atrophy of leg and thigh muscles. Walks with slight limp.

October 20th: Much improved. No fluctuation. Temperature normal.

October 25th: Urine, twenty-four hours 2040 cc., N. 1021, acid. Slight possible trace. Sugar and bile absent. Few squamous and neck of bladder cells. No casts. Occasional small round cell; occasional spermatozoa.

October 29th: No symptom save slight pain on pressure.

November 3d: Occasional attacks of pain referred to outer side of knee, occasionally accompanied by swelling and slight tenderness.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 16.

Male; 73; single; painter.

Fam. Hist.—Negative.

Prev. Hist.—Six or seven years ago had a moderate paralysis affecting left hand and foot, said to have been due to lead. Has partially recovered. No venereal disease; moderate use of alcohol and tobacco.

Pres. Ill.—For two years has had trouble in passing water. Difficult to start the stream, slow in flowing, frequent micturition and apparent inability to completely empty bladder. Has had acute retention requiring catheterization several times. Occasionally blood at the end of micturition; frequently dribbling of urine. Bowels constipated. No severe pain. Mind clear. Has lost a little flesh recently.

Phys. Exam.—Well developed, fairly nourished. No arcus senilis. Marked arterio-sclerosis. Pulse 70, regular, fair volume and tension. Temperature, 99°. No glandular enlargement. Lungs normal except for a few fine moist râles in lower left back without dullness, nor diminished vocal nor tactile fremitus. Heart apparently normal. Abdomen soft and negative. Urine normal, 1018; acid; very slight trace of albumen.

Give detail of further examination necessary to establish a diagnosis.

Give in detail treatment and prognosis of the various conditions that may be present.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 17.

Female; 16; single; schoolgirl.

Fam. Hist.—Negative.

Prev. Hist.—Scarlet fever and diphtheria in childhood. No previous attack similar to present.

Pres. Ill.—Well until three days ago, when she had a sudden sharp attack of general abdominal pain, at first general and then becoming localized in the right lower quadrant. She vomited each evening since, and has been much prostrated. Marked tenderness over seat of pain; both pain and tenderness slightly less to-day. Has felt feverish for forty-eight hours and bowels have not moved. She has been given light foods in moderate quantities. No jaundice. No chills. Menstruation regular.

Phys. Exam.—Well developed; fairly nourished; pale; looks sick, but features are not pinched. Tongue slightly coated. Lungs and heart negative. Pulse 120, fair volume, poor tension. Temperature, 102°. Abdomen distended moderately; considerable general rigidity and involuntary muscular spasm. Tenderness localized in right lower quadrant; in this region the percussion note is dull over an area half the size of palm of hand, elsewhere tympanitic. No mass felt. Urine normal, 1024, acid, very slight trace albumen. Few coarse granular casts. Many leucocytes. Many squamous cells. Leucocytes, 19,800. Slight leucorrhea.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 18.

Male; 13; schoolboy.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Four hours ago patient shot himself with a small pistol, loaded with a blank cartridge. He was trying to adjust the action and the pistol was pointed toward his abdomen. He walked home and was brought to the hospital by parents.

Phys. Exam.—Conscious and in slight pain. Has not vomited nor have bowels moved. Has passed clear normal-colored urine (parents' statement). Has not eaten since accident, but has had several drinks of water. Well developed. General condition good. Pulse, 90; temperature, 98.4°. Heart and lungs normal. Abdomen: just under right costal border, at edge of rectus muscle, is a small, circular, blackened area, with a punctured wound in its center. Around the blackened part is a reddened ring, with very slight induration, redness, heat, and tenderness. There is slight abdominal spasm; abdomen not distended and uniformly tympanitic, including flanks.

Give in detail the diagnosis and treatment. Would you advise immediate celiotomy? Why? What are the serious dangers? Prognosis?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 19.

Female; 70; widow; housework.

Fam. Hist.—Not obtained.

Prev. Hist.—Not obtained.

Pres. Ill.—Patient fell down stairs and was brought unconscious to Relief Station.

Phys. Exam.—Pupils equal and react; tongue protruded in middle line; breathing regular, not noisy. Pulse regular, poor volume and tension. Heart-sounds negative. Abdomen distended, tympanitic, tender in epigastrium. Moves extremities. No vomiting. Contused wound three inches long over left frontal region. Pulse, 100; temperature, 99°.

Later Hist.—Abdominal distention continued. Patient transferred to Main Hospital two days after accident. She was then conscious but vomiting. Urine normal in quality and quantity. There was an indefinite mass in the epigastrium, which was resistant, non-fluctuating and tender with dullness in the flanks, changing with change of position. Vaginal examination negative. Distention and tenderness of abdomen increasing. Pulse, 80; temperature, 99°. Wound of head doing well. No leucocytosis. No movement of bowels for two days.

Is the vomiting a serious symptom?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 20.

Male; 44; single; salesman.

Fam. Hist.—Negative.

Prev. Hist.—Two attacks of gonorrhea, the last one five years ago. Treated by druggist; left epididymitis followed. Had chancroids twenty years ago. Uses alcohol to excess.

Pres. Ill.—Stream of urine has been diminishing in size for one year; frequent micturition with pain at the end of the act. Last week became unable to pass water and "opened" the urethra himself with aid of his spectacles. Has had a very slight discharge from meatus, particularly in the morning.

Phys. Exam.—Well developed. Pulse strong and regular. No glandular enlargement. Lungs and heart normal. Abdomen fat and negative. Penis: small meatus. Bougie à boule, French No. 22, passes to four and a half inches. Beyond this nothing can be made to pass. No induration to be felt along urethra externally. Urine normal, 1018, acid. No albumen. 2 glass test. Many large and small shreds in first glass, few shreds in second glass.

What further examination should be made?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 21.

Male; 28; single; commercial traveler.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—One hour ago patient was standing quietly on the street corner, and was approached by a stranger who asked him to fight. Upon declining the invitation, the stranger stabbed him several times with what seemed to be a large dirty pocket-knife; patient fell, calling for assistance and the stranger fled. Police ambulance immediately brought patient to the hospital. No dressings were applied by the police, as wounds did not bleed much.

Phys. Exam.—Well developed and nourished. Face flushed. Moderate odor of whisky on breath. Tongue moist and slightly coated. Heart and lungs negative. Pulse, 100; temperature, 99°. Has not vomited nor passed urine. Three incised and one punctured wound on body. The incised wounds vary from one to two inches and are about half an inch deep. One is over the left shoulder, the others at the occipito-parietal and left temporal regions. Just below the costal border of left 9th rib is a stab-wound, one inch long, which seems to extend up and toward the median line. Nothing save a little blood exudes from it. Abdomen is soft, without spasm and tenderness, except at the wound itself.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 22.

Male; 38; widower; carpenter.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Four months ago pain began across front of lower part of chest. The pain was sharp, coming in short paroxysms, which were eased by eructations of gas. Three months ago he began to vomit, usually once a day. No undigested masses of food, no blood, no brownish granules in vomitus. The pain diminished. Laxatives in moderate amounts produced a daily but somewhat difficult movement of bowels. No blood in the stools. No jaundice. Has lost fifty-six pounds; feels weak. Gave up work some weeks ago. No cough. Urine negative and normal in amount.

Phys. Exam.—Well developed; poorly nourished. Very anemic; cachectic; skin is harsh and dry. Tongue covered with a brownish dry coat. Temperature, 100°; pulse 110, fair volume and tension, regular. Heart and lungs negative. Knee-jerks present. Abdomen retracted, parietes thin, very little subcutaneous fat. About two inches (5 cm.) above umbilicus is a visible tumor mass, roughly crescentic in shape, moving with respiration, extending from the right mammary line to median line. It is hard, non-fluctuating, somewhat irregular, not tender and not adherent to abdominal wall. It is dull on percussion, but is surrounded by an area of tympany. It may be pressed down upon the aorta and it then transmits the aortic impulse. Hemoglobin, 20%. Leucocytes within normal limits. The temperature, with rare and slight exceptions, continues between 98° and 99°; the pulse ranges from 90 to 110 and does not improve in quality.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 23.

Female; 26; married; housewife.

Fam. Hist.—Negative.

Prev. Hist.—Four children, three dead. Catamenia regular until eight months ago, none since. In past one and a half years has had seven attacks similar to the present one, the first coming one week after the birth of the last child. Attacks have increased in severity, pain becoming more intense and in recent attack extending from original situation in right hypochondrium to right shoulder and even right hip and thigh. Jaundice disappears between the attacks.

Pres. Ill.—One week ago was seized suddenly with intense pain in epigastrium and right hypochondrium radiating to shoulder and hip. Immediate and continued vomiting. No real chills but chilly sensation with sweating. Marked jaundice. Pain relieved by subcutaneous injection. Pain has recurred each day. Bowels have moved four times in past week.

Phys. Exam.—Well developed and nourished. Slightly obese. Skin and conjunctivæ orange-yellow. Thorax negative. Pulse 100, good quality, regular; temperature, 100°. Abdomen markedly protuberant. Symmetrical tumor from pubes to three inches above umbilicus, not tender, not painful, slightly movable but not with respiration. Above this the abdomen is lax. Right hypochondrium is tender. Urine contains bile pigment, otherwise negative. Leucocytosis, 15,000.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 24.

Female; 15; schoolgirl.

Fam. Hist.—Negative.

Prev. Hist.—Pneumonia three years ago. Neither patient nor parents give any history suggesting spinal trouble.

Pres. Ill.—Three days ago pain in back; increased on motion, especially when stooping. At this time parents noticed swelling in back to the right of median line, pain and swelling increasing to date.

Phys. Exam.—Well developed and fairly nourished. Pulse regular, 130, good volume and tension. Heart negative. Temperature, 101°. Abdomen negative. Lungs: bronchial breathing in lower left back. Slight change on percussion. Increased voice sounds. Occasional râle in left apex. Evening temperature, 100°. To the right of the median line, in the back, at the level of the 10th, 11th, and 12th vertebræ, is a fluctuant swelling, size of fist. Free movement in hip-joints. Patient can walk without much pain in back. Leucocytosis, 18,400.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 25.

Female; 32; married; shopgirl.

Fam. Hist.—Not obtained.

Prev. Hist.—Not obtained.

Pres. Ill.—Patient shot in the leg half an hour ago.

Phys. Exam.—Absolutely negative, except for right leg, which showed punctured wound with blackened edges which entered the outside of the right thigh two inches above the upper border of the patella, evidently passing through the external hamstring with a wound of exit on the inside of the leg three inches below the internal tuberosity of the tibia, evidently traversing popliteal space diagonally. No swelling. Pulsation of arteries in foot. No signs of fracture. Temperature of foot normal.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 26.

Male; 40; single; teamster.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—One-half hour before entrance, while riding on a plank between the wheels of a wagon, patient slipped off. Wheel ran over patient's chest, striking right side first. Unconscious. Recovered consciousness in five minutes. Unable to rise. Sharp pain in right side and back, which was continuous.

Phys. Exam.—Well developed and nourished. Cyanotic; reflexes and sensations normal. Lungs negative. Heart-sounds normal. Pulse 100, regular, poor volume and tension. Right side, from 7th rib down, abnormal mobility of ribs with crepitus. Marked tenderness in right flank, more marked toward costal margin. Considerable tenderness in right iliac fossa. Patient put to bed, with chest-swathe. Moderate stimulation and morphia. One hour later passed 12 ounces of urine, being one-quarter or more in volume of blood. Pulse continued to be weak; rate, 110.

Further examination?

Diagnosis? **Prognosis?** **Treatment?**

CASE 27.

Male; 16; single.

Fam. Hist.—Negative.

Prev. Hist.—Tuberculosis of the knee. Operation five years ago. Anchylosis.

Pres. Ill.—One hour before entrance patient was thrown from wagon seat, striking on his right side against a steel post. Did not lose consciousness; was able to walk; taken to the police station half an hour later. While there passed six ounces of bloody-looking urine. Had dull pain in right flank which gradually increased. Taken to hospital.

Phys. Exam.—Face flushed. Pulse equal, regular, rate 100, fair volume and tension. Diffuse pulsation over whole pericardium; short systolic murmur not transmitted. Lungs negative. Abdomen: area of dullness in right flank extends halfway to the median line from costal margin to crest of ileum. Marked spasm and tenderness over this area. Slight ecchymosis over right ileum. Half an hour after entrance, two hours after injury, pulse-rate increased to 120. Patient passed ten ounces of urine, one-third blood.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 28.

Female; 17; single; shopgirl.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Ailing for four weeks. Dull, throbbing headache and dull pain in abdomen. No loss of flesh. Worked up to two weeks ago. Some pain in epigastrium after hearty meals; no vomiting. Bowels regular daily. Abdominal pain was continuous and kept her awake occasionally at night. No cough. Appetite poor.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue: moist white coat. Pulse 88, regular, good volume and tension. Temperature, 102° at night. Heart and lungs negative. Abdomen protuberant, tense, tympanitic in front, slightly dull in flanks, which dullness changes slightly with position. Slight fluid wave. Considerable tenderness and some spasm, largely voluntary. Rectal examination negative. No vaginal discharge.

Diagnosis ? **Prognosis ?** **Treatment ?**

To what is headache due?

CASE 29.

Male; 36; married; carpenter; Swede.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Two hours before entrance to hospital patient slipped and fell astride a wooden horse on which he was standing, striking on his perineum. Got up, resumed work and felt all right except for moderate pain. Ten minutes later he felt something trickling down his leg, and on inspection found blood coming from his meatus. Immediately sought medical advice.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue negative. Heart negative. Pulse good, 60; temperature, 99°. Lungs negative. Abdomen and extremities negative. Inspection of urethra shows blood trickling from meatus. Contusion with slight ecchymosis on inner side of right thigh and perineum. No. 20 sound passed easily to bladder, followed by 26, and then 26 catheter, which was tied in.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 30.

Female; 39; married; housework.

Fam. Hist.—Good.

Prev. Hist.—Scarlet fever, measles, whooping-cough in infancy. "Pleurisy and bronchitis" eighteen months ago for five weeks. No cough since. Three years ago operated for inguinal hernia; no return. One year ago operated for retroverted uterus and cystic ovary. Pain and malaise relieved by this operation.

Pres. Ill.—Constipation began two months ago followed by anorexia, loss of strength, and weight. Constant pain in left middle abdomen; this was at first relieved by pressure, but is now increased by it. No vomiting, no jaundice, no blood or mucus in stools. Slight increase in size of lower abdomen; no change in micturition. Entered the Medical Side of the Boston City Hospital three weeks ago for "bowel trouble." Under rest in bed and careful treatment she improved a little. She is seen in consultation by physicians and surgeons.

Phys. Exam.—Thin, fairly developed; good color, tongue clean and red, pupils react. Pulse regular, fair strength and volume, 95; temperature, 102°. Thorax negative. Breasts small and thin. Abdomen distended, tympanitic, no dullness in flanks. Tenderness and slight spasm in left lower quadrant; nothing felt on palpation. Hemoglobin, 80 %; leucocytes, 17,200.

Diagnosis? **Prognosis?** **Treatment?**

Relation, if any, of previous operations to present condition? Is constipation important?

CASE 31.

Female; 48; married; housework.

Fam. Hist.—Good.

Prev. Hist.—One child; no miscarriages. Distress after eating for eight or ten years; distention and "belching" of gas. Pain, not sharp and biting at intervals of months, referred to left hypochondrium; these attacks last about six weeks. Has had moderate vomiting, never large amounts, never brown or bloody, occasionally greenish; never coughs. Climacteric two years ago; usually constipated; strength good; appetite fair. No serious illness.

Pres. Ill.—About ten days ago she lost her appetite, began to feel weak, was nauseated if she attempted to eat, but did not have pain. She "felt languid." Last night she suddenly spat up a mouthful of blood; this morning vomited "two quarts of blood." She immediately became unconscious; thinks she remained on the floor where she fell about half an hour. Blood was red, not frothy, not accompanied by pain or cough. She has been dizzy and half blind since and has had palpitation. She has lost five pounds in past ten days. Nothing unusual in stools.

Phys. Exam.—Well developed, fairly nourished; very pale and weak. Heart and lungs negative; conscious. Abdomen not distended, no visible tumor; tenderness and slight voluntary muscular spasm in upper half of abdomen. No tumor or deep resistance felt. Nothing abnormal to sight or touch in lower abdomen; universal tympany. Urine negative. Temperature, 100°; pulse 115, regular, low tension. Leucocytes, 14,000. Hemoglobin, about 30%. Reds, 2,200,000.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 32.

Male; '21; single; salesman; Boston.

Fam. Hist.—Negative.

Prev. Hist.—Malaria and typhoid at about 16. Gonorrhea four times; last time one month ago; considerable discharge since.

Pres. Ill.—Five days ago sharp acute pain in right groin and lower part of right side of abdomen. Chill followed by fever. Bowels constipated for two days. Dull pain in right testicle, extending upward; this organ swollen and tender.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue: white coat. Pulse regular, good volume and tension, 110. Temperature, 104°. Heart and lungs negative. Extremities negative. Abdomen: slight spasm in right flank. Spasm and tenderness in right iliac fossa with still greater tenderness in right groin. Right epididymis swollen and tender with cord swollen, tense, and tender. Percussion, uniformly tympanitic; slightly painful in right lower quadrant.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 33.

Male; 30; married; laborer.

Fam. Hist.—Not obtained.

Prev. Hist.—Not obtained.

Pres. Ill.—Five days ago, while in a stooping position, patient was struck on the back by a pile of lumber and bricks which toppled over on him. Unable to move except as to his arms. Vomited several times two days after injury; required catheterization; seemed to have no sensation in his legs.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue protrudes straight. Pulse equal, regular, good volume and tension, rate 100. Temperature, 100.5°. Heart and lungs negative. Knee-jerks absent. No Rabinski. Complete anesthesia to pain, "tough and bony" sensation below the iliac crests, including perineum. Retention of urine and feces. Moderate distention of abdomen. No kyphosis or irregularity of spines. No leucocytosis. Can move legs slowly and with effort.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 34.

Female; 33; married; housekeeper.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Twenty-four hours before entrance, while at home, patient's husband threw her on the floor and kicked her in the left side several times. Patient stated that it "hurt her some" at the time, but she paid little attention to it and went to bed shortly after. Half an hour later was awakened by pain in the left side and was obliged to lie on the other for relief. Next morning was seen by a doctor who, because of continued increasing pain in this region, recommended her transfer to hospital.

Phys. Exam.—Well developed and nourished. Condition of moderate shock, skin being cold and mucous membranes rather pale. Patient lies on the right side with the left knee flexed. Pupils equal and react. Lungs negative. Heart-sounds faint, no murmurs. Pulse 90, weak, poor volume and tension. Abdomen: slightly protuberant, lax, no spasm, very tender in left upper quadrant with an indefinite mass. Signs of free fluid in the abdominal cavity. White count, 8900. Urine: no blood, no albumin. Bowels have not moved nor has patient vomited. Temperature normal. Hemoglobin 60%. What further examination?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 35.

Male; 20; single; painter.

Fam. Hist.—Negative.

Prev. Hist.—For one year patient has had some pain in epigastric region after meals, not all the time but occurring in the form of attacks lasting from three days to a week. Never vomited, except as a result of some excess. Slight loss of flesh and strength the past six months. Otherwise always well and able to work.

Pres. Ill.—One week dull pain in right hypochondrium; twenty-four hours ago sharp pain below right costal margin, shooting toward right scapula. Chills lasted an hour; vomited once. Bowels constipated for the last week. Urine negative. White count, 16,000.

Phys. Exam.—Well developed and fairly nourished. Pupils equal and react. Temperature, 100.3°; pulse, 70. Sclera slightly jaundiced. Tongue: white coat. A faint lead line on gums. Heart: diastolic murmur at apex, not transmitted. Abdomen: no distention; slight general spasm; considerable spasm and tenderness in right hypochondrium extending to, but not below, McBurney's point. No mass.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 36.

Female; 13; single.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Ten days ago fell while running and bruised right thigh, outer side, just below hip-joint. Next day, while at school, it began to pain. Went home and found thigh somewhat swollen. Swelling and pain increased. Remained in bed. Felt slightly feverish; no chill.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue: slight white coat, dry. Pulse 120, good volume and tension. Heart negative. Lungs negative. Abdomen negative. Right thigh swollen, hot, tender as to its upper two-thirds. Outer aspect, three inches below trochanter, shows point of greatest swelling and tenderness, with slight fluctuation. No glands in groin. Pain is evidently rather severe. Temperature, 99°. Flaxseed poultices thirty-six hours. At the end of that time, pulse 100, temperature 104°. Local condition practically the same. Leucocytes, 15,500.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 37.

Male; 27; single; conductor.

Fam. Hist.—Negative.

Prev. Hist.—Always well.

Pres. Ill.—For five days increasing swelling in throat, region of both tonsils. Inability to open mouth. Pain much worse on right side. No chill.

Phys. Exam.—Pupils widely dilated, do not react. Pulses equal, slightly irregular in rhythm, good volume and tension. Heart: normal in size; no murmurs. Throat shows general reddening, slight swelling of both tonsils. Bimanual examination with finger in mouth shows tender indurated mass in the neck below, and to the base of, the tongue. Twenty-four hours later patient has complained of continuous severe pain. Examination of the throat same as at entrance. Severe pain on swallowing. Pulse, 120; temperature, 103.5°, evening. Leucocytes, 20,000. Some tenderness under chin.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 38.

Female; 46; married; housekeeper.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Rather nervous temperament. For past two months attacks of sharp pain in epigastric region, not referred. Attacks last two to four days, and occur four or five times a month. Always accompanied by chill and vomiting; onset always sudden. Jaundice always present during attacks, but varies in amount and always subsides with the attack. Last attack three days ago. Bowels move daily, rather light colored. Menstruation regular.

Phys. Exam.—Sclera slightly jaundiced. Fairly developed. Has not lost flesh. Abdomen not protuberant, soft, tympanitic, no spasm. Slight tenderness confined to the epigastric region. No tumor. Pulse, 90; temperature, 99.5°. Urine negative. No leucocytosis.

Diagnosis? **Prognosis?** **Treatment?**

Treatment of individual attacks? Of underlying condition?

CASE 39.

Male; 42; married; laborer.

Fam. Hist.—Negative.

Prev. Hist.—Smallpox at 16. Four and a half years ago compound fracture of left leg low down. Wounds cleaned and dressed; fracture reduced; gangrene. Five weeks later amputation, middle and lower thirds. Necrosis of skin-flap. Discharged with large, sluggish, granulating wound. At no time since has it been entirely healed. More or less pain. Bought a wooden leg; never able to use it. Could not stand pressure.

Pres. Ill.—Three weeks ago wound and stump grew worse and more painful.

Phys. Exam.—Obese. Arteriosclerosis. Pupils equal and react. Pulse regular, good volume, rather high tension. Lungs negative. Abdomen negative. Left leg amputated, middle and lower thirds. Lower five inches of stump red, indurated, slightly tender. Sinus over the end of bone, one inch deep. Sloughing area about it, size of a quarter. Small sloughing ulcer, size of nickel; anterior surface of stump, two inches from end. At this point skin is adherent to bone.

Diagnosis? **Prognosis?** **Treatment?**

Probable cause of previous gangrene?

CASE 40.

Female; 36; married; seamstress.

Fam. Hist.—Negative.

Prev. Hist.—Always well except for three miscarriages.

Pres. Ill.—Six months ago cough with some expectoration in the morning. Hoarseness began four months ago; has grown steadily worse. Has lost fifteen pounds. Occasionally sweats a little at night; no subjective fever. Seven weeks ago a swelling appeared on left side of neck, extending to median line, which increased in size, making swallowing difficult for past two weeks.

Phys. Exam.—Well developed and nourished. Hoarse voice, speaks in a coarse whisper. Pupils normal. Tongue: slight dry coat. Pulse regular, fair volume and tension, 100. Heart absolutely negative. Lungs: dullness, increased vocal and tactile fremitus, a few crackling râles and prolonged expiration in left apex. Abdomen negative. Extremities negative. Neck shows swelling extending from clavicle to top of thyroid cartilage, size of palm of hand, mostly to the left side, indurated, tender, slightly red, fluctuant.

Further examination?

Diagnosis ? **Prognosis ?** **Treatment ?**

What effect does pulmonary condition have upon treatment?

CASE 41.

Female; 60; widow.

Fam. Hist.—Negative.

Prev. Hist.—Fourteen children and two miscarriages. Moderate constipation.

Pres. Ill.—Has noticed swelling of entire abdomen for two weeks, increasing more rapidly past four days. Not much pain. Always somewhat constipated. Past three days no movement. Cathartics freely used. Little headache; no vomiting.

Phys. Exam.—Well developed and fairly nourished. Tongue: moist, slight brown coat. Pulses regular, fair volume and tension, rate 80. Heart normal except for slight irregularity. Lungs negative except for a few moist râles in left lower back. Abdomen not much distended above umbilicus. Below this point, dome-shaped eminence extending to pubes. No mass felt. Tympanitic throughout. Visible peristalsis and gurgling, no spasm, no rigidity. Very little tenderness. Vaginal and rectal examinations negative. Temperature normal. Treatment: high enema gave very slight result; no gas; next two days efforts to move bowels with cathartics and enemata failed. Abdominal distention the same. Temperature and pulse same. General condition as evidenced by facies not quite so good.

Further examination?

Diagnosis? **Prognosis?** **Treatment?**

CASE 43.

Male; 39; married; electrician.

Fam. Hist.—Negative.

Prev. Hist.—Stomach trouble for two years—that is, frequently pain after meals; much worse past five weeks; always pain after meals; occasional vomiting; no blood. Lost twenty pounds of flesh in past month.

Pres. Ill.—Two days ago had a slight attack of faintness. That morning noticed stools were black and offensive; very weak toward evening. Next day unable to get up. Five hours ago patient had another attack of weakness with increasing pallor. Began to feel restless. Abdominal pain; nausea; no vomiting. Given a subcutaneous injection, character unknown, before entrance to hospital.

Phys. Exam.—Well developed and nourished. Very pale; anxious expression; mucous membranes blanched; restless. Pupils small, do not react. Tongue: dry, slight brown coat. Pulse regular, 100, fair volume and tension. Heart negative. Lungs negative. Abdomen tender in epigastric region; slight general spasm; no signs of fluid.

Diagnosis ? **Prognosis ?** **Treatment ?**

Probable significance of pupils ?

CASE 44.

Male; 41; married; cook.

Fam. Hist.—Negative.

Prev. Hist.—Gonorrhea twenty years ago. Slight rheumatism two years ago, not accompanied by chills or sweats. Habits moderate.

Pres. Ill.—About one week ago was seized with sudden pain which started in small of back and shot around to the front. Pain extremely severe, lasting but a short time; slept well and next day passed three small stones from meatus. No blood. Passed water thirty hours ago and has not been able to pass any since. Pain in lower front abdomen, not elsewhere. Has not vomited.

Phys. Exam.—Well developed and nourished. Conscious. Pupils react, tongue slightly coated. Pulse regular, fair volume and tension, not rapid. General condition good. Temperature normal. Lungs normal. Heart: apex not seen; percussion and auscultation show it to be in the 5th space, one and a half inches outside nipple line; no thrill; one inch dullness to right of sternum. Soft systolic murmur at apex transmitted to axilla but not heard at back. Second pulmonic accentuated. Abdomen tense and distended; dullness over pubes halfway to umbilicus. Slight shifting dullness in flanks. Urine bloody, 1010, neutral. Albumen a trace; sediment, much normal blood, considerable large white cells on day after entrance. Penis: meatus very small; palpation reveals a hard, resistant, nontender mass apparently within the urethra, one inch from meatus.

Diagnosis? **Prognosis?** **Treatment?**

In what way does cardiac condition affect the case?

CASE 45.

Male; 77; married; laborer.

Fam. Hist.—Negative.

Prev. Hist.—Not obtained.

Pres. Ill.—Slightly constipated for four or five weeks; otherwise about the house as usual. Four days ago good movement of bowels in evening. Since then nothing except little gas first two days, past two days nothing. Four days ago discovered hard irreducible lump in left groin, size of egg, slight pain attracting his attention. Pain gradually increased with vomiting twice two days ago, several times yesterday and to-day. Patient states that he never knew he was "ruptured."

Phys. Exam.—Well developed and fairly nourished. Looks somewhat anxious. Considerable sclerosis. Pulse good volume, fair tension, 80; temperature normal. Heart and lungs negative. Abdomen moderately distended, rigid with involuntary spasm, slightly tender. Hard lump in left groin, apparently below Poupart's ligament, size of egg. Not tympanitic, irreducible. Treatment: high enema, good result. Operation: under cocaine, tumor found to be strangulated omentum through femoral opening. Omentum black. Excised. Skin and muscle closed through-and-through sutures. Half an hour after operation, while left alone for a few minutes, patient stood on his feet by side of bed. Perfectly comfortable through night and following day with normal temperature and pulse below 90. Second day after operation patient vomited three times; vomitus foul, fecal. Repeated enemata gave no result. Abdominal distention appeared and rapidly increased with tenderness and pain. Anxious look returned. Pulse continued to be good, at 90 to 100; temperature normal.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 46.

Female; 46; married; housekeeper.

Fam. Hist.—Negative.

Prev. Hist.—Pneumonia in childhood. Rheumatism at 6, in bed five weeks. Erysipelas at the same time. Four children, no miscarriages. Catamenia continue regular. Has had cough with yellowish expectoration six months.

Pres. Ill.—Two weeks ago this became worse. Had a chill, felt feverish. In bed since then. Bowels have moved every day, sometimes three or four times a day. Appetite poor. Thirst excessive. No vomiting. Indefinite general abdominal pain for these two weeks. No specially tender place. Lost "considerable" flesh. No night-sweats.

Phys. Exam.—Well developed and poorly nourished. Pale. Pupils equal and react. Tongue: dry, slight white coat. Pulse regular, fair volume and tension, 96; temperature, 103.5°. Heart negative. Lungs: dullness in both apices with bronchial breathing; crackling râles, more on right. Abdomen: rigid, tympanitic, considerable general tenderness and spasm, liver not felt. Spleen not felt but slightly enlarged by percussion. White count, 8000. Widal negative.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 47.

Female; 22; married.

Fam. Hist.—Negative.

Prev. Hist.—Two years and a half ago operation for ventral suspension. Separation of pelvic adhesions which had evidently followed mild pelvic inflammation. Small cyst removed from left and one from right ovary. Both ovaries and tubes slightly swollen. Patient has been married three years; has never been pregnant.

Pres. Ill.—Two weeks ago painful and profuse menstruation, which lasted about a week. Two days ago return of pain in pelvic region. No movement of bowels for three days. No vomiting.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue: slight white coat. Pulse regular, 95; temperature, 102°. Heart and lungs negative. Abdomen slightly distended. Some general spasm and tenderness, both being a little more marked in the lower half of abdomen, but about equal as to sides. Vaginal examination reveals nothing except increased resistance on right side. Few hours after entrance patient had excellent result from high enema. Passed a fairly comfortable night. Twenty-four hours later (being thirty-six hours after patient was first seen) pulse, 130; temperature, 99°. Distention somewhat increased. Slight dullness in lower half of abdomen. Tenderness and spasm somewhat increased. Pain remained about the same, according to amount and character. Patient looks anxious.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 48.

Male; 30; Chinese; single; laundryman.

Fam. Hist.—Negative.

Prev. Hist.—Negative. Denies venereal diseases.

Pres. Ill.—Three months ago noticed moderate soreness on inner side of left thigh, just above knee. Thinks he may have struck it, but has no recollection of any particular accident. This area has gradually swollen, accompanied with very slight pain and tenderness. Recently there has been slight limitation of motion. He has not had a chill and has not felt feverish, though his temperature has been slightly elevated on at least one occasion. He has continued his work until three days ago.

Phys. Exam.—Well developed and nourished; has not lost flesh. Heart, lungs, abdomen, and urine negative. Left thigh, inner aspect just above condyle, a moderate swelling, firm and possibly slightly fluctuating, slightly tender, not reddened; apparently not adherent to the bone, though appears to be attached to the soft parts directly above the bone. Knee-joint normal except for slight limitation of active motion. Surface temperature not increased. No leucocytosis. No glands in groin. Pulse 80, regular, strong; temperature, 99° (evening). Appetite good.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 49.

Female; 35; single.

Fam. Hist.—Good.

Prev. Hist.—Has had "dyspepsia" for several years; typhoid (moderate severity) ten years ago. Never jaundiced.

Pres. Ill.—While under treatment for nervous dyspepsia, complicated by insomnia and moderate neurasthenia, was attacked by sudden, severe, burning pain referred to epigastrium. Immediate vomiting of dark greenish thin liquid—no blood (either now or at any previous time). At the end of the vomiting patient became unconscious, had a slight tonic convulsion; no biting of tongue, no foaming at lips. Recovered consciousness and vomited twice again, then becoming semi-conscious, still complaining of severe pain. Has previously been passing sixty to eighty ounces of urine of low specific gravity and without albumen.

Phys. Exam.—Fairly developed and nourished; pupils equal and react; skin brown; expression of pain but not anxiety; conscious but disinclined to speak; frequent large eructations of gas from stomach. Heart and lungs negative. Abdomen tender, slight muscular spasm in upper half, no dullness, tympanitic everywhere; no jaundice. Pulse regular, poor volume and ranging from 70 to 80. Temperature normal. Severe headache; pupils equal and react. Moderate pressure on abdomen is not unpleasant. Pain extends upward and to the left; legs not drawn up. Urine but fifteen ounces in past twenty hours, high color, 1014, neutral, no albumen.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 50.

Female; 23; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—One child, two years old; no miscarriages. For about one year irregular pain in lower abdomen; constant leucorrhea; occasional frequent micturition. Has felt poorly but has done her own housework until three weeks ago.

Pres. Ill.—Pain and tenderness increasing and referred to lower abdomen, more particularly on the right. Pain moderately severe, dull, not sharp or stabbing in character. Constipated but did not vomit. No cough. Admitted to Medical Ward. Mild diet, cathartics, rest in bed, sedatives. General condition improved somewhat, but abdominal symptoms persisted.

Phys. Exam.—Pale, fairly developed, poorly nourished. Heart and lungs negative. Tongue coated. Pulse regular, fair strength, 80; temperature, 99.5°. Urine negative. Abdomen not distended. Striæ of pregnancy present. Moderate tenderness in right lower quadrant. No leucocytosis. No tumor felt.

Further examination?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 51.

Male; 36; married; teamster.

Fam. Hist.—Negative.

Prev. Hist.—Negative. Denies venereal; moderate drinker. Has been teaming for a wool firm.

Pres. Ill.—Five days ago noticed a pimple about size of a pin's head on right upper cheek. It gradually increased in size but without much pain. Two days ago the "pimple" was opened in an out-patient department. Since then it has increased more rapidly and the swelling has partially closed the eye.

Phys. Exam.—Well developed and nourished. Pupils equal and react. No general glandular enlargement. Heart and lungs negative. Urine normal. Abdomen and genitals normal. Knee-jerks normal. Over right malar bone is a hard, brownish, ulcerated area, size of five-cent piece, around which is some redness and several vesicles. Much swelling and edema about eye which is closed tight. Not much pain or tenderness.

Further examination?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 52.

Male; 26; married; carpenter.

Fam. Hist.—Good, except that a half-sister died of phthisis.

Prev. Hist.—Good. Always well; denies venereal; no alcohol. Has been married six months. Just before marriage noted for the first time a small painless lump in right testicle.

Pres. Ill.—Five months ago suddenly began to feel weak, with headache, fever, and anorexia; constipation followed by slight diarrhea, which persisted; general malaise. Was unable to work, but did not stay in bed for more than a day or two. After four or five weeks he began to feel better and his appetite returned. He resumed work for a while, gained weight and felt fairly well. Then pain in back appeared, soon becoming very severe, and was noticeably worse at night; it was referred to left lower back. Since then has been "good for nothing," though not confined to bed. In past few weeks has noticed slight increased frequency of micturition, but nothing abnormal in appearance of urine. No chill, nausea, vomiting, or sweating.

Phys. Exam.—Fairly developed and nourished; cheeks slightly flushed; stands with rigid back and walks with left-sided limp, which is not entirely typical of either hip- or spine-disease. Eyes clear; tongue clean. Heart and lungs negative. A small specimen of urine passed at 10.30 A. M. was 1020, pale, slightly acid; no albumen. Right testis somewhat enlarged, slightly tender; on posterior surface a nodule, three-quarters of an inch in diameter, firm, not movable, slightly tender, non-fluctuating. Back is rigid in lumbar region, and erector spinæ muscles are tense, but there is no knuckle in the spinal column, and motion is little if at all limited. Abdomen relaxed; in upper left quadrant is a tumor—tense, tender, smooth, convex downward, projecting below the edge of the ribs. From this tumor an indurated cord runs downward and inward in a direction similar to that of the ureter. The right kidney is palpable and slightly tender. Abdomen otherwise negative. Rectal examination demonstrates a slightly tender prostate, which is not enlarged. Pulse, 80; temperature, 99°.

Further examination?

Diagnosis? **Prognosis?** **Treatment?**

Prognosis with and without treatment?

CASE 53.

Female; 37; married; laundress.

Fam. Hist.—Negative.

Prev. Hist.—Five children, last one two years ago; no miscarriages. Has always been of a nervous temperament. Occasional attacks of indigestion, that is, once in three months has what she calls bilious attack.

Pres. Ill.—Sense of soreness in lower part of abdomen for two weeks. Bowels loose, two to three movements daily. Vomited half a dozen times in past two weeks. Had a slight chill this morning. Was struck a light blow on the stomach three days ago, followed by some abdominal pain. In bed past three days. Catamenia present two weeks ahead of time. Patient says she has had frequent headaches of a dull character in frontal and occipital regions. Occasionally has attacks of vertigo. Has cramps in the legs at night. Is very "nervous."

Phys. Exam.—Well developed and nourished; troubled expression; does not look sick. Pupils equal and react. Tongue: slight white coat. Pulse regular, rather high tension, 120; temperature, 101°. Right leg and right arm moderately anesthetic. Heart negative. Lungs negative. Abdomen considerably distended with marked general voluntary spasm and tenderness; rigidity almost board-like. No leucocytosis.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 54.

Male; 48; married; woodworker.

Fam. Hist.—Negative.

Prev. Hist.—Moderate use of alcohol; otherwise negative.

Pres. Ill.—One year ago noticed a swelling near right sterno-clavicular joint, which burst, discharging thin pus, one month later. The discharge has continued since that time, though patient has been treated in an outpatient department for nearly eight months. He has had at least one incision, presumably for drainage, in the neck. The scar of this incision is in the middle line. About eight days ago a swelling appeared at the upper part of the sternum. This became reddened and gradually developed fluctuation. There was very slight pain and moderate tenderness accompanying it.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue clean. Pulses equal and regular, fair volume, high tension. Heart area normal, no murmurs. Abdomen soft, not tender nor distended, tympanitic everywhere save in left flank, where it is dull. Extremities negative. Knee-jerks present. Slight general glandular enlargement. Urine negative. Pulse, 90; temperature, 99.5° (night). Swollen and reddened area over upper sternum about the size of palm of hand. Probe reaches bare bone through a small sinus.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 55.

Male; 34; single; salesman.

Fam. Hist.—Father died of a "shock."

Prev. Hist.—Gonorrhea eight years ago. Still has gleety discharge at times. Moderately alcoholic.

Pres. Ill.—Fell down a flight of stairs to-day, injuring head, left shoulder, and right thumb. Was unconscious for some hours. Coughs frequently.

Phys. Exam.—Conscious. Well developed and nourished. Pulse: good volume and tension, not frequent nor very slow. Pupils equal and small, react slowly both to light and accommodation. Heart negative; no râles in lungs. Abdomen not tender, tympanitic. Moves all extremities except right arm, and this apparently due to pain. Knee-jerks present; no anesthesia. Bleeding from left ear. Pain in right shoulder; no crepitus nor abnormal mobility. Temperature normal. Urine negative. Two days later got out of bed in an aimless fashion "to catch some rats." Fingers tremulous, looks anxiously about ward, does not sleep. Anorexia. Talks in a low voice to himself part of time. Reflexes lively. No retraction of head. Pulse and temperature rising. No paralysis. Urine negative.

Diagnosis? **Prognosis?** **Treatment?**

CASE 56.

Female; 49; married; housework.

Fam. Hist.—Negative.

Prev. Hist.—Vomited blood once, several years ago. Never any gastric symptoms since.

Pres. Ill.—Three months ago was accidentally struck on the left breast by her husband's elbow. Slight pain and tenderness followed. Within a few days she discovered a "lump" in this breast, which has gradually increased in size. In other respects she is perfectly well, so far as she knows.

Phys. Exam.—Well developed, plump, color good. Heart, lungs, and abdomen negative. Urine normal. Bowels regular. Left breast not enlarged, tender, nor inflamed. In upper inner quadrant is a hard mass, irregularly ovoid in shape, not tender nor painful, not adherent to skin or subjacent muscle. This mass is larger than the average English walnut and is flattened. Nipple normal in size, shape, and color, and not retracted. She has not lost flesh. No glands in the axilla, so far as can be discovered by touch.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 57.

Male; 29; single; teamster.

Fam. Hist.—Not important.

Prev. Hist.—Typhoid at 20. Cramps in abdomen; have been a common occurrence for ten years, sometimes with vomiting. No pain after meals; distress does not seem to be associated with food. General health good.

Pres. Ill.—Five days ago sharp attack of cramps, much like previous attack. Subsided as usual, but left considerable pain in right hip which has continued. No headache; no vomiting; no chills. Pain somewhat increased with movements of right thigh.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue moist, slight white coat. Pulse 80, good volume and tension. Temperature normal. Heart and lungs negative. Abdomen slightly tender throughout, more so in the right lower quadrant, with pain which is referred to the right anterior superior spine and extending down the right thigh. Slight tenderness in right groin. No fullness; no mass in abdomen. Four days later tenderness persisted, also pain. Laparotomy showed inflammation of the appendix with a very small amount of pus in an apparently well walled-off cavity, deep in the pelvis, below and behind cecum. Appendix removed. Drainage. Ten days later slight discharge from sinus. Wound granulating. Patient still complained of even more severe pain in the right hip and groin, and now has tenderness in right groin extending down thigh to a point eight inches below Poupart's ligament. Slight swelling of upper half of right thigh; very slight fullness in groin; no fluctuation. Ten days later increase in these symptoms with marked fullness in groin. Considerable swelling of thigh with tenderness and a deep sense of fluctuation on the outer side of right thigh extending up toward groin. Patient now has irregular temperature, reaching 101° at night; pulse, about 100. Has lost weight, looks sick, as if suffering from some chronic disease. No special distressed or peritoneal look; sleeps well after mild opiate.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 58.

Male; 42; single; provision dealer.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Has had pain referred to left jaw for seven days. Recently a swelling has appeared at site of pain, which he also feels in floor of mouth.

Phys. Exam.—Well developed and nourished. Tongue slightly coated. Heart, lungs, abdomen, and urine normal. Knee-jerks present. Fluctuating swelling over and below ramus of left lower jaw, tender and reddened. Also a sinus in left side of floor of mouth, leading down to roots of teeth, which may be felt with a probe. Mouth not dry. Leucocytes, 15,200.

Diagnosis? **Prognosis?** **Treatment?**

CASE 59.

Female; 18; single; Germany; housework.

Fam. Hist.—Negative.

Prev. Hist.—Always well. Patient confesses to having spent past thirty days in a house of questionable character.

Pres. Ill.—Two days ago fell off curbstone and twisted her ankle. Immediate disability which lasted only a few minutes. Next day walked as usual. That night went to a dance, walking and dancing without pain. Next day ankle swollen, considerable pain. Profuse vaginal discharge for past two weeks. Pain on micturition.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue clean. Pulse, 90; temperature, 100°. Heart and lungs negative. Abdomen negative. Reflexes normal. Slight swelling over internal malleolus of right foot; some tenderness, not sharply localized at any point. Pain on motion. Ecchymosis considerable. No signs of crepitus or abnormal mobility made out. Four days later swelling diminished; tenderness slight; plaster cast. Four days later patient up; very little pain on motion of ankle; slight swelling and tenderness remain. Two weeks after injury patient again in bed. Tenderness and slight swelling in both groins. Tenderness in both iliac fossæ. Temperature again averages 100°; pulse, 90. Ankle is now considerably swollen, very tender and painful. Vaginal examination shows tenderness and slight induration on both sides of cervix; uterus only slightly movable.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 60.

Male; 34; married; blacksmith.

Fam. Hist.—Negative.

Prev. Hist.—Three years ago attack of abdominal pain with nausea and vomiting, tenderness, constipation. Diagnosis of attending physician—appendicitis. Recovered quickly without operation.

Pres. Ill.—Four days ago taken with cramps in abdomen. Went to bed. Past two days vomited three times. No chills. Pain has been cramp-like, seems to occupy whole of abdomen. No tenderness.

Phys. Exam.—Well developed and nourished; does not look sick. Pupils equal and react. Tongue moist, clean. Pulse regular, 60; temperature, 98.6°. Heart and lungs negative. Abdomen: no tenderness or spasm to speak of. Abdominal pain seems to be relieved rather than increased by pressure in epigastric region.

Further examination?

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 61.

Male; 22; student; New Hampshire.

Fam. Hist.—Negative.

Prev. Hist.—As a child had mumps, measles, chicken-pox, whooping-cough, and quinsy sore throat. Six years ago, after pitching hay in the daytime, was seized about midnight with sudden pain in the lower abdomen which "doubled him up." He vomited and had diarrhea. His abdomen became distended and was extremely tender. He was given salts but no food for four days; in bed three weeks. The pain was more severe in the right lower quadrant. Went to school in the following year, but did not take exercise. Nine months after came a second similar attack, but without vomiting. He was in bed two weeks.

Pres. Ill.—No attacks since, but says if he exercises violently he has slight tenderness in the right side which passes away in a few hours. This worries him. Sleep, appetite, and bowels are normal. He never feels feverish or chilly; no variation in health or strength. Micturition slightly more frequent but otherwise normal. He now remembers that he had the "yellow jaundice" when fourteen years old. No pain at that time.

Phys. Exam.—Well developed, fairly nourished, thin. Heart and lungs negative. Abdomen negative, save for slight tenderness on deep pressure over a point one-third from right anterior superior spine of ilium toward umbilicus. After running a mile or doing hard physical work, he feels sore at this spot. Urine high colored, 1020, acid, no albumen; temperature, 98.6°; pulse, 60. No leucocytosis.

Diagnosis? **Prognosis?** **Treatment?**

How important is the mental element in this case? Would you recommend operation? If so, when? May he finish six weeks' college work? If no operation, give treatment in detail.

CASE 62.

Female; 28; married; housework; Ireland.

Fam. Hist.—Negative.

Prev. Hist.—Typhoid at 19. Three miscarriages, each at four months. Hysterectomy three years ago. Patient says this followed an illness of three months, with much pain. Since operation patient has been well, except for habitual constipation.

Pres. Ill.—Ten days ago patient was taken with cramp-like pain in the abdomen. The bowels had not moved for five days, though patient had taken salts twice during that time. Headache and dull pain in the abdomen has greatly increased. Eight days ago slight movement of bowels. Three days ago another slight movement and fainted while at stool. Appetite poor past three weeks. Pain in the abdomen more severe yesterday and to-day than at any other time. Not localized in any particular spot.

Phys. Exam.—Well developed and nourished. Pupils normal. Tongue: dirty brown coat. Pulse regular, good volume and tension, 100; temperature, 100°. Heart and lungs negative. Abdomen full in flanks. No fluid wave. Slight general tenderness, a little more marked in right iliac region. No spasm. Vaginal examination negative. Rectal examination: no ballooning; no feces felt. Extremities negative. Leucocytes, 8500. Urine negative.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 63.

Female; 20; single; waitress.

Fam. Hist.—Negative.

Prev. Hist.—Denies venereal. No previous gastric trouble.

Pres. Ill.—Sharp, stabbing pain in lower abdomen twenty hours ago. Vomited several times since; no blood in vomitus. No chill. Catamenia regular, stopped flowing one week ago. Bowels regular.

Phys. Exam.—Conscious and in pain. Well developed, fairly nourished. Pallid; respiration rapid and superficial; restless. Pulse 150, very feeble. Temperature, 99°. Heart and lungs negative. Urine negative. Abdomen universally tender, slightly rigid, and moderately and uniformly distended. Moderate voluntary and involuntary muscular spasm of abdominal parietes. Tympanitic about umbilicus; dull in flanks. Rectal examination shows tenderness high up on right side. No vaginal examination made (patient unmarried). High enema produced good result. Patient vomited brown material just after entrance. No vaginal discharge. No leucocyte count made.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 64.

Male; 32; married; born in Russia; shoe dealer.

Fam. Hist.—Not obtained.

Prev. Hist.—Never sick in bed.

Pres. Ill.—Past five years lump size of fist in right chest, just above nipple; never painful or tender; not increased in size for more than three years. Yesterday, while standing on the platform of a train, suddenly thrown against the iron railing, striking against this tumor, also against head; unconscious for a few minutes; recovered; assisted to a seat; later walked home. Next morning no head symptoms except slight dizziness. Tumor appeared to be considerably larger. Pain in this region considerable. Patient states positively that tumor is now three times the size it was before the injury. Coughs occasionally.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue: white coat. Pulse, 80; temperature normal. Dullness with diminished respiration and absent fremitus over patch size of palm, region of angle left scapula, behind. Right lung normal. Abdomen negative. Knee-jerks not obtained. Right chest shows tumor mass size of half a head extending from right nipple to and over clavicle, on to shoulder. Soft and not fluctuant. Lower portion firmer than upper portion. Skin apparently not stretched to any great extent. Small area of ecchymosis size of palm over this tumor, in the region of clavicle. For following five days there was no change in physical signs, but patient complained of steady and somewhat increasing pain, which he said was sufficient to keep him awake at night. Urine normal. No leucocytosis.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 65.

Male; 23; single; salesman.

Fam. Hist.—Good.

Prev. Hist.—Negative.

Pres. Ill.—While playing baseball was struck on the outer side of the left leg, near the ankle, by a batted ball. Severe pain followed by numbness resulted, with partial disability. He continued, however, to play for some time. Limped home with a cane. Bathed foot in hot water, put on a bandage, and moved around the house for two days. Did not feel feverish. Consulted physician on the fourth day.

Phys. Exam.—Well developed and nourished. Heart, lungs, abdomen, and urine normal. Perfectly well except for left leg which is slightly swollen in lower half; tender and painful. Surface temperature slightly increased. Swelling most marked over lower quarter of fibula and below it. Ecchymosis extends from one inch below fibula halfway up outside of leg. Tenderness most marked and acute one inch above tip of external malleolus. No crepitus; no deformity. Can support part of weight on left foot, but only with considerable pain referred to and above outer ankle. Gentle antero-posterior motion of ankle-joint not painful; lateral motion moderately painful. Dorsalis pedis pulsates. No glands in groin. Pulse, 80; temperature, 99°. Sleeps fairly well, but wakes with a jump if leg is moved suddenly.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 66.

Male; 53; married; hackman.

Fam. Hist.—Negative.

Prev. Hist.—One year ago "operation on knee," character impossible to determine. Gonorrhea three times, last attack twenty years ago. Three or four drinks daily.

Pres. Ill.—Nine days ago a painful pimple appeared on back of neck; it has steadily increased in size and in pain and tenderness. General malaise; slight fever; neck very sore and stiff. Says he gets up once to "make water" at night. Drinks as much as "any other man."

Phys. Exam.—Fairly developed; pale. Heart and lungs negative. Extremities, including knees, apparently normal save for operation scar. Constipated. On back of neck from middle line forward to left ear, and from level of tip of ear to upper edge of scapula, is a purplish brawny swelling, indurated and peppered with numerous small yellow foci of pus and sloughs, from one of which a moderate quantity of sero-sanguino-purulent liquid escapes. This swelling is hot and very tender. Pulse, 110; temperature, 103.5° and rising. Urine 1038, pale, acid, slight trace albumen, 1.84 % sugar. Acetone and diacetic acid present.

Diagnosis? **Prognosis?** **Treatment?**

Is operation indicated? What contraindications? What anesthetic? Details of operation? Details of after-treatment?

CASE 67.

Male; 61; married; laborer.

Fam. Hist.—Good.

Prev. Hist.—Always healthy.

Pres. Ill.—Six days ago was well. On the following day had pain in right hand. Does not remember injuring it in any way. Pain and swelling steadily increased. Has had chills. Was attended by a physician who sends him to hospital to-day.

Phys. Exam.—Well developed, fairly nourished. Looks very sick. Pulse 100, regular, rather weak, poor tension; temperature, 103° (afternoon). Eyes, heart, and lungs normal. Moderate arterio-sclerosis. Respiration, 30. Abdomen negative. Right arm and hand swollen to twice their normal size, red or reddish brown throughout. Very tender and painful. Fluctuation in forearm and over olecranon. Upper arm, wrist, and hand indurated. Numerous bluish-brown blebs; radial pulse may be detected. Skin universally tense. No glands in axilla or at elbow. 18,000 leucocytes. Urine 1010, acid, high color, slight trace albumen.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 68.

Male; 22; single; wood chopper; Polish.

Fam. Hist.—Negative.

Prev. Hist.—Negative. Denies venereal. Habits good.

Pres. Ill.—Nine weeks ago was struck on right thigh by falling tree. He managed to reach a house two miles distant without assistance. Was taken to a "hospital" and for eight weeks remained in bed. Patient talks only patois, and no further details can be obtained.

Phys. Exam.—Very well developed and nourished. Pulse and temperature normal. Heart, lungs, abdomen, and urine negative. Cannot stand on right leg. Right thigh: marked outward deformity at middle bone much thickened; no crepitus nor tenderness; no inflammation; entire thigh apparently involved. Right leg one and three-quarter inches shorter than left. Moderate tenderness at site of tumor. Leucocytes, 8200.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 69.

Male; 26; married; laborer.

Fam. Hist.—Negative.

Prev. Hist.—Children's diseases. No previous head injury. Habits moderately alcoholic.

Pres. Ill.—Said to have fallen in the street several hours ago. Brought to hospital in police ambulance.

Phys. Exam.—Semiconscious. Can be roused by supra-orbital pressure; when roused, answers incoherently. Does not know what happened to him. Strong odor of alcohol on breath; has evidently vomited. No bleeding from nose, mouth, or ears at present. Pupils small and unequal, left being smaller; they react sluggishly to light. Moves limbs; apparently no paralysis. No fractures of trunk or extremities. On left parietal eminence a contusion and abrasion with considerable swelling and infiltration; no obvious depression of bone. Pulse, 100; temperature, 97.6°. No leucocytosis. Urine negative.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 70.

Female; 24; single; housework.

Fam. Hist.—Negative.

Prev. Hist.—Was in hospital three months ago for "tumor of knee"; was operated. Never jaundiced.

Pres. Ill.—One week ago severe pain in right side of abdomen, becoming general; no vomiting. Pain has diminished. Bowels constipated; has been in bed four days; no chill. Catamenia regular.

Phys. Exam.—Poorly developed and nourished; pallid. Pupils normal; slight internal strabismus. Lips dry and partly covered with sordes. Tongue coated and dry. Pulse 100, regular, fair strength; temperature, 100.2°. Heart and lungs negative. Leucocytosis, 15,000. Reflexes normal. Abdomen slightly distended and tender, latter more marked on right side. Slight muscular spasm most marked on right. No definite tumor felt. Rectal examination shows large fecal mass. Vaginal examinations negative except for slight tenderness in right vaginal vault.

Diagnosis? **Prognosis?** **Treatment?**

CASE 71.

Male; 66; married; carpenter.

Fam. Hist.—Negative.

Prev. Hist.—Always well. Three years ago examination of urine showed "slight" amount of sugar. Lived on mildly restricted diet since.

Pres. Ill.—One year ago horse stepped on left foot. Small lacerated wound which healed. In a few weeks pain returned; gradually increased in severity ever since. Three months ago noticed small black spot outer side great toe. At this time two and a half per cent. of sugar in urine. Diabetic diet and increasing doses of codein up to five grains three times a day do not decrease sugar nor relieve pain. Gangrenous area did, however, slightly decrease and become dry and covered with a crust. Not much increase in amount of urine. Frequency of micturition. No special thirst. Appetite good; has lost twenty-five pounds in past year. Past week gangrenous area appears to be slowly increasing. Pain severe.

Phys. Exam.—Well developed and nourished. Pupils equal, react. Tongue moist; slight white coat. Pulse regular; slight arteriosclerosis; rate 90. Heart negative. Lungs: resonance good, harsh respiration at right apex; no râles. Abdomen negative. Knee-jerks not obtained. Gangrenous area on great toe size of a half-dollar. Sugar, two and a half per cent. No acetone.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 72.

Male; 48; single; steward.

Fam. Hist.—Negative.

Prev. Hist.—Has been subject to occasional attacks of indigestion. Latterly a moderate amount of alcohol.

Pres. Ill.—For a week or two has had indigestion. Attack of pain came on about 10 A.M.; severe general abdominal cramp, more in upper than in lower part; severe enough to absolutely disable him and extremely sudden. Came to hospital that day, pain then abating.

Phys. Exam.—Abdomen uniformly distended and tender; tympanitic. No tumor. Enema resulted in fair movement and much decrease of distention. Temperature about 100°. Leucocytes, 14,000. Was seen next day; then not distended, but tender over eighth left costal cartilage, and just below it, more especially just below the tip of the eighth costal cartilage, left side. Some little spasm. Gall-bladder region free; appendix free. Nothing palpable anywhere. Percussion showed small stomach; liver not abnormal; spleen not discoverable. No jaundice. Yesterday's urine 1040, marked sugar; to-day's 1030, no sugar; examination otherwise negative. Next day trace of bile in urine, 1029, no sugar. Abdominal conditions better. Tenderness more nearly at level of umbilicus. Little pain, spasm less. At about three days seemed nearly well, though still some soreness. Then temperature went up again—irregular temperature; reached maximum of 103°; pulse not correspondingly light. No increase of pain. Leucocytes, 8000 to 13,000 throughout. No sugar at any time since the first.

Diagnosis ? **Prognosis ?** **Treatment ?**

CASE 73.

Male; 37; married; barber.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Right inguinal hernia for ten years; in scrotum for past five years. Occasionally has some difficulty in reduction. Never strangulated. Business requires him to stand up, which for past few months has caused him considerable pain. Constipated.

Phys. Exam.—Well developed and nourished. Pupils equal and react. Tongue clean. Heart area, sounds, and action normal. Lungs negative. Abdomen negative except for left inguinal ring, which admits two fingers. Pulsation on cough. When patient is erect a mass the size of an incandescent light globe appears in scrotum. Operation; radical cure, Bassini. Perfectly normal convalescence for two weeks with first intention wound. At this time, following attempt to move the bowels, patient had fainting spell and was found with rapid respiration, rapid pulse, some dyspnea, and slight cyanosis. Symptoms gone in about an hour. Enema moved bowels freely; patient perfectly comfortable. Next day patient felt perfectly well, anxious to get up. At noontime had a second and very sudden onset of dyspnea with marked cyanosis and rapid respiration, weak and rapid pulse, cold perspiration. Foot of bed elevated. Shock enema. Subcutaneous stimulation. Bowels moved freely as result of shock enema. Slight improvement in symptoms during next hour. Pulse returned to wrist, rate 120. Next four hours slight cyanosis and rapid respiration persisted, but patient appeared to be fairly comfortable. Pulse regular and rapid. At this time cyanosis and dyspnea suddenly appeared; pulse again left the wrist. Heart again became rapid and irregular. Examination of heart (before negative) now showed slight enlargement to the right, downward, apex being in the sixth space, where before it had been in the fifth. Diminished respiration and moist râles right axilla and back.

Diagnosis? **Prognosis?** **Treatment?**

CASE 74.

Male; 25; single; painter.

Fam. Hist.—Negative.

Prev. Hist.—Negative.

Pres. Ill.—Fell from roof of Adams Square Subway Building, striking his head. Brought into Relief Station semiconscious, with a pulse of high rate and poor quality, very irregular. Wound at left vertex, with a linear fracture of the skull, running transversely. This was cleaned and dressed. After about an hour there began to be blackening of the left eye. Was seen about two hours after the accident.

Phys. Exam.—He was dull, semiconscious, rational, lying quiet, without spasm. Temperature, 99°; pulse 80, fair quality, not characteristic—now not irregular. No paralysis of limbs. Reflexes normal. Left orbit swollen and blackened, with much sub-conjunctival hemorrhage. No hematoma about bridge of nose on right eye. As he lay quiet there was marked divergence of the left eye out and up; this lessened *somewhat* as he was roused. The pupil reacted to light, but was much smaller than on the right. The right pupil larger than pupils average. No bleeding from ears; some bleeding from nose. Urine negative.

Diagnosis? **Prognosis?** **Treatment?**

CASE 75.

Female; 39; married; Canada; housewife.

Fam. Hist.—Negative.

Prev. Hist.—Typhoid fever eighteen years ago. Eight children, no miscarriages.

Pres. Ill.—Patient states that about three weeks ago began to have throbbing pain in fourth finger of her left hand, with some swelling, redness, and tenderness. No knowledge of injury. One week later finger was opened by physician. Two weeks after onset, second incision. Process now involved whole hand. Later more and free incisions of finger. Daily dressings.

Phys. Exam.—Well developed and nourished. Rather pale. Pupils react; right larger than left. Patient says it has been so for years. Tongue dry. Pulse regular, good volume and tension, 105. Slight arteriosclerosis. Heart and lungs negative. Abdomen negative. Spleen just felt. Extremities negative, except left hand which shows open sinus extending whole length of fourth finger; necrotic material; bone exposed. Swelling and redness of palm and dorsum. Daily dressings; soaks. Doses of strychnia. Four days later removal of two distal phalanges, flaps not united. Twenty-four hours later patient had considerable hemorrhage in the dressing. These hemorrhages recurred at intervals of from twelve to twenty-four hours for a week, sometimes following dressing; sometimes occurring several hours after being dressed and bandaged. Septic processes meanwhile improved rapidly. Blood examinations made at this time showed hemoglobin 25 per cent.; red corpuscles, 250,000,000; white corpuscles, 135,000. Differential count: polymorphonuclear neutrophiles, 69 per cent.; small mononuclears, 5 per cent.; large mononuclears, 7 per cent.; mast cells, 4 per cent.; myelocytes, 14.7 per cent.; rarely any eosinophiles; some variation in size of reds. Tendency to paleness; moderate polychromatophilia. Spleen now increased in size until it extended a hand's breadth below costal margin.

Diagnosis? **Prognosis?** **Treatment?**

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